

Michael P. Santa Maria, Ph. D.
Board-Certified Neuropsychologist; Diplomate, Clinical Neuropsychology (ABPP-CN)
1825 Maple Road, Suite 200
Williamsville, NY 14221
Phone (716) 687-8748
Fax (716) 687-8753

A confirmation call will be made to the phone number provided to us 2-3 days prior to your appointment. All appointments must be confirmed by you or, per policy, the appointment will automatically be cancelled. If your telephone number changes, please contact our office immediately to notify us of the change.

Please read this entire page in order to be prepared for your evaluation.

- Spinal cord stimulator or pain pump implant candidate pre-evaluation, pain management evaluation, or bariatric surgery candidate evaluation -- 2-3 hrs.

Please bring the following:

- Insurance referral form/prior authorization number(s) (if required) or script from referring physician
- **Insurance card and/or pertinent insurance information (Workers Compensation/No-Fault, etc.)**
- **Driver license, passport or other photo identification.**
- **Co-pay, if applicable, is due at time of visit(s).**
We accept cash, check, money order, or credit card
(checks should be made out to "Neuropsychology and Psychology Services")
WE ONLY ACCEPT VISA OR MASTERCARD.
***NOTE:* Most insurance plans charge a co-pay for the testing date **and** the return/follow-up date for the results.**
- Any copies of medical records, or head CT or MRI reports which you may have on hand.
- **The enclosed paperwork, completed and signed should be brought with you at time of visit.**

****If the patient is on medication for an attention deficit (ADHD), please do not have the patient take the medication the morning of the testing. You should bring the medication with you in case it should become necessary later in the day.**

Thank You.

PATIENT INFORMATION

Marital status

PATIENT: _____ Female ___ Male ___ _____

ADDRESS: _____ DATE OF BIRTH: ___ / ___ / ___ SS#: _____

CITY/STATE/ZIP: _____ HOME PHONE: _____

PRIMARY CARE PHYSICIAN: _____ Phone #: _____

REFERRING PHYSICIAN: _____ Phone #: _____

WORK PHONE: _____ HIGHEST EDUCATION LEVEL COMPLETED: _____

If patient is a child or has a guardian, provide name of parent(s) or legal guardian: _____

Relationship: _____ Address: _____

Phone: _____ Work Phone: _____ Cell: _____

Is this visit covered by one of the following? If so, circle the applicable choice.

WORKERS' COMP NO-FAULT DISABILITY INSURANCE

If you did not circle one of these, proceed to the Health Insurance section below.

If you did circle one of the above, complete this section and the Health Insurance section below.

CARRIER CLAIM #: _____ Date of Injury: _____ Workers' Comp Board # (if applicable): _____

Name of insurance carrier: _____ Carrier or adjuster's phone number: _____

Carrier address: _____

ATTORNEY (IF RECORDS SHOULD BE SENT TO HER/HIM): _____ Phone: _____

Full Address: _____ Your signature authorizing release: _____

PRIMARY HEALTH INSURANCE (complete this section even if this is a workers' comp or no fault case):

- Blue Cross/Blue Shield Empire Railroad Medicare
Child Health Plus Independent Health Tricare
Family Health Plus Independent Health Medisource Univera
Nova Medicaid Univera Senior Choice
GHI Medicare Other

ID Number: _____ Group: _____ Policy Holder: _____ SS#: _____

Policy holder's Employer: _____ Patient's relationship to policy holder: SELF SPOUSE CHILD OTHER

SECONDARY HEALTH INSURANCE:

- Blue Cross/Blue Shield GHI Nova
Community Blue Independent Health Railroad Medicare
CB Child Health Plus Independent Health Medisource Tricare
CB Family Health Plus Medicaid Univera
Empire Medicare Univera Senior Choice
Other

ID Number: _____ Group: _____ Policy Holder: _____ SS#: _____

Policy holder's Employer: _____ Patient's relationship to policy holder: SELF SPOUSE CHILD OTHER

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM (S). I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Neuropsychology and Psychology Services, P.C., for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents (in the case of Medicare) or to my agency or insurer any information needed to determine these benefits or the benefits payable to related services. This also applies to Workers Compensation claims, where health information may be exchanged with the insurance carrier and the Workers Compensation Board. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of information to the agency or insurer shown.

(SIGNATURE OF LEGALLY RESPONSIBLE PARTY)

(DATE)

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BILLING POLICY

- This office participates with numerous insurance companies and accepts assignment from many. It is your responsibility to provide us with accurate and sufficient billing information to determine whether our services are covered by your insurance contract. You can check coverage and receive answers to questions regarding your policy by calling the telephone number on the back of your insurance card.
- If your insurance company requires that you have a referral for services rendered in this office, it is your responsibility to obtain that referral and present it at the time of treatment. If you fail to obtain that referral, resulting in the denial of our claim by your insurance company, you will be responsible for payment for services billed. **You are also responsible for co-payments, deductibles, etc. as determined by your insurance company. A \$5.00 billing fee will be charged to all accounts with outstanding co-pays, billed each time after 30 days.**
- If we do not participate with your insurance or if you do not have insurance, payment in full is expected at the time of your visit.
- If No Fault or Workers' Compensation is your primary insurance for this visit, you are responsible for providing us with accurate information regarding the insurance carrier's name and address, the date of the injury, WBC# and Carrier Case number. If your insurance carrier denies payment, all outstanding balances are your responsibility unless you have a personal health insurance that covers those services rendered.
- If we receive a payment denial of our claim(s) from your insurance company or other contracted payor of services, you will be responsible for payment.
- Note: Responding to Forensic/Medical Legal requests, conferences and telephone calls with attorneys involve additional time and record keeping. The Responsible Party is responsible for all direct costs and expenses associated with Dr. Michael P. Santa Maria and his attorney(s) responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to, court appearances, preparation of reports, photocopying, faxes, long-distance telephone calls, out of office travel, overnight delivery and courier services. These expenses are billed to the Responsible Party and to the Patient's/Responsible Party's Attorney. The Responsible Party, however, remains responsible for payment of these charges if not paid in full within sixty (60) days. The above noted direct cost and expenses are understood and accepted to be in addition to any published federal and/or state statutes, which may otherwise apply.
- **CANCELLATION FEE: Unless a testing appointment is cancelled more than 24 hours in advance, there will be a cancellation charge of \$150 to the Responsible Party. This is due to the large block of time set aside for testing.**

I have read the above billing policy of this office and my agreement to abide by its terms is signified by my signature.

Patient's Name (printed) _____

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

For Office Use Only:

- Insurance information verified
- Card(s) copied
- Co-pay paid \$ _____

PRIVACY NOTICE

We understand our patients' rights to privacy and confidentiality with regard to their medical records. We have a policy of keeping your medical records and other information received from you and your health care providers confidential. We pledge to protect your medical records in accordance with federal and state privacy laws. This notice provides information on how we protect your personal health and financial information.

Protected Health Information

We in this office are committed to safeguarding your protected health information (**PHI**) in accordance with applicable state and federal laws, rules and regulations. We protect this information from improper disclosure through staff training, by limiting staff access to only those records necessary for proper completion of required tasks, by securing our buildings and computer systems, and by entering into agreements with business partners that include confidentiality promises and safeguards.

Disclosure of Protected Health Information

The following outlines various circumstances under which we may disclose your PHI:

- For Treatment: We may disclose your PHI to physicians and medical personnel and staff in the office that has referred you to this office to obtain necessary information for your care and to appraise them of the results of your evaluation and to provide them with a basis and recommendations for your continued care.
- For Payment: We may disclose you PHI to your insurance company in order to bill for services rendered, to obtain authorization from your insurance company, to collect on claims filed, to sort out coordination of benefits when more than one insurance is thought to be involved and/or to any individual or entity involved in the payment of or the securing of payment of your medical bills.
- As Required by Law: We may disclose PHI when required by federal, state, or local law to do so, i.e., by the courts, health oversight bodies, or other entity which has legal jurisdiction regarding such.
- To a Parent or Guardian: We may disclose the PHI of a child under the age of eighteen to a parent, guardian, or person with similar legal status as allowed or required by New York State law.
- In Case of Victim Abuse: We may disclose your PHI to notify the appropriate authority in the case of abuse or neglect when required by law.
- Inmates: We may disclose the PHI of an inmate to correctional institutions or law enforcement officials for the health, safety or security of the inmate, the institution or other individuals.
- Workers' Compensation: We may disclose your PHI to the extent necessary to comply with workers' compensation laws.
- Research: Under certain circumstances we may disclose your PHI for research purposes. In research situations your medical information may be reviewed to determine suitability for the research project. In this case, the PHI does not leave our office and is not further used by the researcher unless chosen for the study, at which time we would ask for your permission for its use and identifying information would not be shared. In these instances, our agreements with these researchers or other providers require that the information we disclose be used for a limited, well-defined purpose and that it be appropriately safeguarded.

Your Rights

You have the right to request any of the following: (a) a paper copy of this disclosure, (b) an appointment to review your PHI, (c) a change to your PHI if you feel it is incorrect or incomplete, (d) an accounting of non-treatment disclosures (disclosed after April 14, 2003, and for a stated time period of not longer than six years). Any request should be made in writing to **Privacy Officer, Buffalo Neuropsychology; 1825 Maple Rd.; Ste. 200; Williamsville, NY 14221**. Your written request should be specific and in the case of item (c) above include supporting reasons for your request for amendment. There may exist certain limited circumstances where a request may be denied.

For requests to disclose your personal health information that are not identified in this Privacy Notice, not permitted under applicable state and federal laws, rules and regulations and are not in the regular course of our business, we ask for and receive your written authorization before any information is disclosed. Such authorization may be revoked by you at any time in writing; however disclosures already made can not be rescinded.

The undersigned acknowledges that he/she has read the foregoing Privacy Notice.

_____ (Signature of patient or legal representative of patient)

Print patient's name on the following line. _____

Confidential Background Information Form

Patient Name: _____

Date: _____

Referred by: Provider's name: _____, _____

Date of birth: _____ / _____ / _____

Race: Caucasian African-American Hispanic Asian Native American Other

Sex: Female Male

If yes, please answer the following questions within the chart below:

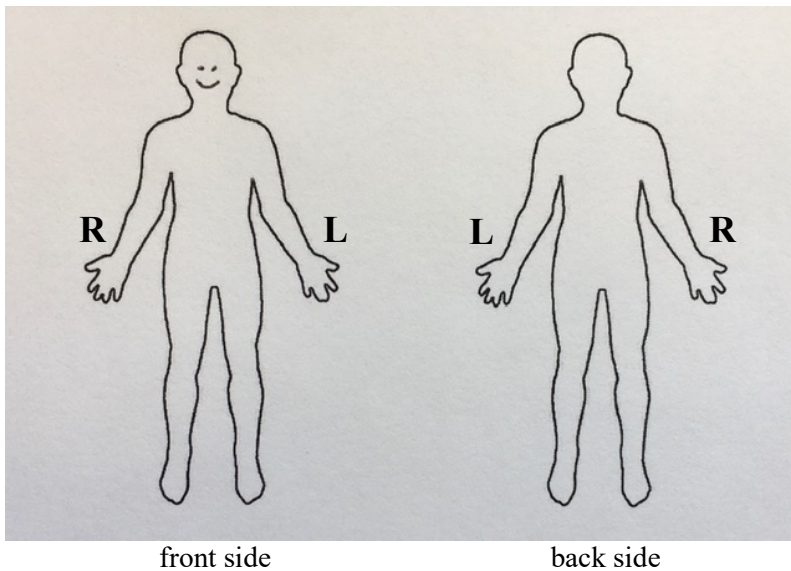
Have you ever utilized any of the following:	Please circle Yes or No	When? (What years?)	Where? (What facility?)	How effective was this in reducing your pain? (circle one choice)
Physical therapy	Yes No			Not effective mildly moderately very effective
Heat packs	Yes No			Not effective mildly moderately very effective
Cold packs	Yes No			Not effective mildly moderately very effective
TENS unit	Yes No			Not effective mildly moderately very effective
Epidural injections or other steroid injections	Yes No			Not effective mildly moderately very effective
Behavioral pain management	Yes No			Not effective mildly moderately very effective
Chiropractic treatment	Yes No			Not effective mildly moderately very effective
Acupuncture	Yes No			Not effective mildly moderately very effective
Massage therapy	Yes No			Not effective mildly moderately very effective
Dorsal column stimulator	Yes No			Not effective mildly moderately very effective
Intrathecal morphine pump	Yes No			Not effective mildly moderately very effective
Pain medication	Yes No			Not effective mildly moderately very effective

If yes, please answer the following questions within the chart below:

Have you had any of the following surgeries?			When? (What year(s)?)	Where? (What hospital/facility?)	What procedure was done?
Neurosurgery/brain surgery	Yes	No			
Heart surgery/bypass surgery	Yes	No			
Back/spinal surgery (list all)	Yes	No			

If yes, how effective was back surgery in reducing pain? Not effective Mildly Moderately Very effective

Presently, where is the pain? Please mark or sketch the location of pain on illustrations below.



Circle all that apply. Pain frequently is:

- Burning
- Dull
- Gnawing
- Itching
- Numb
- Pulsating
- Radiating
- Sharp
- Shooting
- Stabbing
- Tearing
- Tingling
- Twisting
- Other: _____

Please answer the following questions about your pain level on a scale from 0 to 10 on which 0 is no pain and 10 is the worst pain you have ever experienced.

What is the lowest your pain level can get to?	1	2	3	4	5	6	7	8	9	10
What is the highest your pain level can get to?	1	2	3	4	5	6	7	8	9	10
What is your pain level on average?	1	2	3	4	5	6	7	8	9	10
What is your pain level at today? (answer on day of appointment)	1	2	3	4	5	6	7	8	9	10
Did you take any pain medication today? (answer on day of appointment)	Yes					No				

Have you ever had any of the following procedures? Please circle yes or no:

<u>Procedure</u>	<u>Yes or No?</u>		<u>If so, about when?</u>	<u>If so, where?</u>
EEG (electoencephalogram)	Yes	No	_____	_____
CAT scan (CT) of the brain/head	Yes	No	_____	_____
MRI of the brain/head	Yes	No	_____	_____

Please list **current medications**, dosages, and frequency:

<u>Medication</u>	<u>Start Date</u>	<u>Prescribing Physician</u>	<u>Dosage</u>	<u>How Often?</u>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Have you ever had any of the following? (Please circle) **If yes, when was condition first apparent?**

Yes	No	Head injury with loss of consciousness	_____
Yes	No	Seizures: If yes:	_____
		Type (convulsive/nonconvulsive):	_____
		Ages (started and stopped)/Total #:	_____
		Any loss of bladder/bowel control?:	_____
Yes	No	Stroke	_____
Yes	No	Tumor or cancer: If yes:	_____
		Location:	_____
		Treatment:	_____
Yes	No	Heart attack	_____
Yes	No	High blood pressure (hypertension)	_____
Yes	No	High cholesterol	_____
Yes	No	Diabetes	_____
Yes	No	Thyroid condition: If yes, what type?	_____
Yes	No	Incontinence	_____
Yes	No	Asthma	_____
Yes	No	Emphysema	_____
Yes	No	Liver disease	_____
Yes	No	Sleep Apnea	_____
Yes	No	Alcohol abuse	_____
Yes	No	Drug abuse	_____
Yes	No	Prescription medication abuse	_____
Yes	No	Cigarette smoking/chew/vaping/e-cigs	_____
Yes	No	Marijuana/THC usage (smoking or edible)	_____

Other medical conditions: _____

Please provide information about any inpatient treatment for mental health or alcohol/drug abuse:

<u>Name of Hospital/Clinic</u>	<u>When were you hospitalized?</u>	<u>For how long?</u>	<u>Reason</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please provide information about any outpatient psychiatric treatment, psychotherapy, or counseling:

<u>Name of Therapist</u>	<u>Name of Hospital or Treatment Center</u>	<u>Month & Year that Therapy Began</u>	<u>Month & Year that Therapy Ended</u>	<u>How Often?</u>	<u>Reason</u>
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

City of birth _____

Is your mother living? Yes No **Is your father living?** Yes No
 If yes, is she in good health? Yes No If yes, is he in good health? Yes No

Do you have any siblings? Yes No ***If yes, please fill out the table below**

	How many are living?	How many are deceased?	How many are full siblings?	How many are ½ siblings through your mother?	How many are ½ siblings through your father?
Sisters					
Brothers					

How many years of education have you completed? _____
 If applicable, list high schools attended: _____
 If applicable, list colleges attended: _____
 Degree or number of semesters? _____

Ever enrolled in special education? Yes No
 If so, beginning in which grade? _____

Ever held back a grade in school? Yes No
 If so, which grades? _____

Ever served in the military? Yes No
 Combat experience? Yes No
 If so, branch of service: Army Navy Air Force Marines Coast Guard
 Which years you were in the service? _____
 Type of discharge? _____

Are you presently employed? Yes No
 If no, why not? _____

Past two jobs you have held: Indicate if Full Time or Part Time

	<u>Employer</u>	<u>Job Title</u>	<u>Dates Employed</u>	<u>Reason for Leaving</u>	<u>Full or Part Time</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____

Any other sources of income?: Social Security Workers' Comp Pension Alimony Social Services

What city or town do you live in presently? _____

Marital Status (circle applicable): Single Married Separated Divorced Widowed

Number of marriages: None 1 2 3 Other: _____

If married, in what year were you married? _____

If divorced or separated, in what year? _____

Please list your children including their ages:

	Sex	Age	Name
1.			
2.			
3.			
4.			
5.			

Presently, with whom do you live? _____

Ever been arrested? Yes No When? _____ Charges? _____
 DWI? DUI? DWAI? Yes No When? _____ License Suspended? _____
 Prison time? Yes No When? _____
 Currently on probation? Yes No Since when? _____
 Currently on parole? Yes No Since when? _____

Are you able to do the following on your own?

Shower/take a bath	Yes	No
Get dressed	Yes	No
Cook simple meals	Yes	No
Laundry	Yes	No
Housecleaning	Yes	No
Take medications	Yes	No
Grocery shopping	Yes	No
Pay bills	Yes	No
Manage a bank account	Yes	No
Drive a car	Yes	No

Comments: _____

If no, how long have you been unable/who assists you?

Which of the following do you like to do for fun? (circle all that apply):

- | | | | |
|-----------------|---------------|------------------------|--------------------|
| Watch TV | Sewing | Spend time with family | Automotive |
| Listen to music | Arts & crafts | Casino/Gambling | Camping |
| Video games | Gardening | Shopping | Fishing |
| Walking | Bike riding | Travel | Hunting |
| Football | Baseball | Volunteer work | Reading |
| Basketball | Hockey | Golf | Walk dog |
| Lift weights | Running | Cooking | Gym/Fitness center |

Others: _____

Copays are due at time of check in.

We accept cash/check/credit card or money orders. We only accept Visa and Mastercard.

*Please note that there is a 3% fee for credit cards